REMARKS
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Address to European Union Health Ministers
eHealth 2006 High-Level Conference and Exhibition
Málaga, Spain

Good afternoon. I'm delighted to have this opportunity to talk with you about the steps we're taking at the U.S. Department of Health and Human Services to advance health information technology. I want to talk about how we see the problem and the approaches we're taking to reach solutions.

In the United States, and in many of your countries, health care is consuming an ever-increasing portion of our economy. This by itself isn't necessarily bad. What is bad, however, is that much of that increase is due to the inefficiency inherent in the outdated system. And that is threatening all of our economic competitiveness.

Consider:

- In 1960, 5.1% of America's GDP was spent on health care.
- Today, that rate has more than tripled to 16% of our GDP, or $1.9 trillion.
- It is estimated that by 2015 it will be close to 20% of our GDP.
- One single program—Medicare, which provides seniors and Americans with disabilities hospital insurance, medical insurance, and prescription drugs—now consumes 3.4% of our GDP. At the current rate of growth, by 2040 it will consume 8.1%. By 2070, 14%.

This not only cannot be allowed to happen, it simply will not be possible for it to come to pass. Either the system will change, or we will cease to be economically competitive, for there's no country with a successful economy that dedicates so much to one sector.

Though the health care system in America is excellent, medical errors are far too prevalent. As many as 44,000 to 98,000 deaths occur in America each year as a result of medical errors. Clinical information is frequently missing at the point of care, and that missing that information can be harmful to patients. And more than 1 out of every 5 Americans say that they or a family member has experienced a medical or prescription drug error. When each medical error is estimated to cost an average of $3,700, the great cost of this inefficiency becomes apparent.

President Bush, Secretary Leavitt, and I believe that nothing short of a bold transformation of our health care system will do. We believe that the proper realization and implementation of health information technology is key to this transformation.

Currently, groups across the free market agree with this vision and are moving forward. Unfortunately, many are moving forward in a manner similar to the development of the railroad industry more than a century ago.

In the mid-nineteenth century, there were several railroad companies competing against one another. Railroads were a significant improvement over past means of transportation. But the

companies all had different standards: they used different gauges of track—how far apart the rails were spaced. Some were 4 feet 8 ½ inches. Some were 5 feet. Some were 5 feet 3 inches. The tracks couldn't connect, and cars on one set of tracks couldn't travel on other tracks.

This meant that while you could get from one place to another very quickly while you were on one company's tracks, to go long distances you would have to stop and change trains every now and then. This wasn't very efficient, and it kept the railroads from meeting their potential.

Fortunately, under the leadership of President Lincoln and Congress, a consensus was reached in the late nineteenth century, and it was decided that railroads in America would have a gauge of 4 feet 8 ½ inches. We benefit from a single interoperable rail network to this day.

Believe it or not, in other countries, however, this debate expensively rages on even today, a century and a half later.

Right now we're at a crossroads with health I.T. People are spending millions of dollars on health information technology systems, but too many of them cannot communicate with one another. And in the absence of larger standards, there's no telling how they will be able to communicate with future systems either.

We see five key elements of success: interoperability, standards harmonization, compliance certification, establishing a nationwide health architecture over which health records will travel, and removing hurdles to adoption.

There are three general ways that we can establish standards, and avoid a long and expensive debate.

- One, we in the government could just pick a standard and mandate its use, or switch to it and use our dominate market position to force everyone to use it. This sounds easy, but almost never works, because it isn't able to accurately capture the good ideas from the free market and health I.T. is more complex than setting a railroad gauge.
- Two, we can allow for survival of the fittest, and wait for vendors can fight it out. But, as we see with the railroad standards, that can take a very long time, and we might find ourselves with the high-tech equivalent of fancy rail cars with no tracks on which they could run.
- Or three, government can work with the free market in a guided collaboration. We can work to achieve consensus, if possible, so that when we implement health I.T, we can do so in a positive way.

Our role as the federal government is to guide and stimulate the process, not dictate it. At HHS, we are involved in several initiatives that will help drive this utilization of health I.T..

During his 2004 State of the Union Address, President Bush charged us with the aggressive goal of making electronic health records available to a majority of Americans within ten years. To achieve that goal, last fall, Secretary Leavitt chartered and is now chairman of a Federal Advisory body called the American Health Information Community, or simply the Community. Because we are such a massive purchaser of health care, we must be careful not to act before we

have consensus. We view interoperability standards as a central goal and a key piece of on which all the other parts depend. Accordingly, the Community is comprised of government officials along with leaders in the free market, and is tasked with making recommendations to Secretary Leavitt on how to achieve a single standard for interoperable electronic medical records that maintain security and respect patient privacy.

The Community has identified four areas, or crystallizing events, that offer the most promise for immediate progress, and they are working to achieve implementation within the year:

- **Bio-surveillance**—enabling the transfer of standardized and anonymized health data from the point of health care delivery to authorized public health agencies within 24 hours of its collection;
- **Consumer empowerment**—making available a consumer-directed and secure electronic record of health care registration information and a medication history for patients;
- **Chronic care**—allowing the widespread use of secure messaging, as appropriate, as a means of communication between doctors and patients about care delivery; and
- **Electronic health records**—creating an electronic health record that includes laboratory results and interpretations, that is standardized, widely available and secure.

As I mentioned, President Bush gave us a goal of ten years to make electronic health records available to all Americans. We are moving very aggressively on a number of elements to meet that goal. By next week, we expect to accept a certification process for ambulatory electronic health records. By next year, we expect to have a certification process for the hospital-based electronic health records systems in place. And the following year, we expect to have a similar certification process for NHIN architectures which will allow standardized networks to be built in the free market.

I've been meeting with my European counterparts on a number of different issues, and one thing I have learned from my interactions with them is that we communicate too little. Far too often, we struggle with the same issues and have to solve the same problems. We all essentially reinvent the wheel. Now that I've explained a little about what we are doing in the United States on questions of health information technology, I hope we can find opportunities for collaboration and areas where we can share our best practices. Thank you.